New Hampshire HEALTHY KIDS

# Application

## Healthy Kids Medical Insurance or Medical Coverage for Pregnant Women

**Healthy Kids Medical Insurance** is health and dental insurance for children under age 19. Some families may have to pay premiums and copayments.

**Medical Coverage for Pregnant Women** is free health insurance for pregnant women of any age. It also covers dental care for pregnant women under 21.

### Tell us **who you are and where you live.**

| | | | |
|---|---|---|---|
| First name: Middle initial: Last name: | | | Social Security Number *(you must answer this if you are applying for yourself):* |
| Home phone: | Work phone: | Cell/Msg: | |
| Street address *(no P.O. Box):* Apartment number: | | City: State: Zip code: | |
| Mailing address *(if not the same as street address):* | | City: State: Zip code: | |
| Have you ever used a different name or names? ☐ **Yes** ☐ **No** *If* **yes,** *please list:* | | | Language you speak at home: |




**Need Help?**

Call **1-877-464-2447.** You can call Monday to Friday, 8:00 am to 4:30 pm.
The call is free. **TDD:** 1-800-735-2964

## Tell us about **each child living with you who is under age 19.**

### Child 1

First name: | Middle initial: | Last name: | Social Security Number *(only if applying for medical coverage):*

Birth date *(month/day/year):* | This child is: ☐ Male ☐ Female | Is this child a student? ☐ Yes ☐ No

What is this child's race or ethnic origin? *(you do not have to answer this question):*
☐ American Indian/Alaskan Native ☐ Native Hawaiian/other Pacific Islander ☐ Asian ☐ Black/African American
☐ White ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other *(please tell us)* .....

Are you applying for this child? ☐ Yes ☐ No | Is this child a U.S. citizen? *(answer only if applying for this child):* ☐ Yes ☐ No | Does this child have special healthcare needs? ☐ Yes ☐ No

**List the child's parents, stepparents or legal guardians who live in your household.**

**1.** Name of ☐ Mother ☐ Stepmother ☐ Legal guardian | Birth date *(month/day/year):*

**2.** Name of ☐ Father ☐ Stepfather ☐ Legal guardian | Birth date *(month/day/year):*

### Child 2

First name: | Middle initial: | Last name: | Social Security Number *(only if applying for medical coverage):*

Birth date *(month/day/year):* | This child is: ☐ Male ☐ Female | Is this child a student? ☐ Yes ☐ No

What is this child's race or ethnic origin? *(you do not have to answer this question):*
☐ American Indian/Alaskan Native ☐ Native Hawaiian/other Pacific Islander ☐ Asian ☐ Black/African American
☐ White ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other *(please tell us)* .....

Are you applying for this child? ☐ Yes ☐ No | Is this child a U.S. citizen? *(answer only if applying for this child):* ☐ Yes ☐ No | Does this child have special healthcare needs? ☐ Yes ☐ No

**List the child's parents, stepparents or legal guardians who live in your household.**

**1.** Name of ☐ Mother ☐ Stepmother ☐ Legal guardian | Birth date *(month/day/year):*

**2.** Name of ☐ Father ☐ Stepfather ☐ Legal guardian | Birth date *(month/day/year):*

### Child 3

First name: | Middle initial: | Last name: | Social Security Number *(only if applying for medical coverage):*

Birth date *(month/day/year):* | This child is: ☐ Male ☐ Female | Is this child a student? ☐ Yes ☐ No

What is this child's race or ethnic origin? *(you do not have to answer this question):*
☐ American Indian/Alaskan Native ☐ Native Hawaiian/other Pacific Islander ☐ Asian ☐ Black/African American
☐ White ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other *(please tell us)* .....

Are you applying for this child? ☐ Yes ☐ No | Is this child a U.S. citizen? *(answer only if applying for this child):* ☐ Yes ☐ No | Does this child have special healthcare needs? ☐ Yes ☐ No

**List the child's parents, stepparents or legal guardians who live in your household.**

**1.** Name of ☐ Mother ☐ Stepmother ☐ Legal guardian | Birth date *(month/day/year):*

**2.** Name of ☐ Father ☐ Stepfather ☐ Legal guardian | Birth date *(month/day/year):*



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**Child 4**

First name: Middle initial: Last name:

Social Security Number *(only if applying for medical coverage):*

Birth date *(month/day/year):*

This child is: ☐ **Male** ☐ **Female**

Is this child a student? ☐ **Yes** ☐ **No**

What is this child's race or ethnic origin? *(you do not have to answer this question):*
☐ **American Indian/Alaskan Native** ☐ **Native Hawaiian/other Pacific Islander** ☐ **Asian** ☐ **Black/African American**
☐ **White** ☐ **Hispanic or Latino** ☐ **Not Hispanic or Latino** ☐ **Other** *(please tell us)* .....

Are you applying for this child? ☐ **Yes** ☐ **No**

Is this child a U.S. citizen? *(answer only if applying for this child):* ☐ **Yes** ☐ **No**

Does this child have special healthcare needs? ☐ **Yes** ☐ **No**

**List the child's parents, stepparents or legal guardians who live in your household.**

**1.** Name of ☐ **Mother** ☐ **Stepmother** ☐ **Legal guardian** Birth date *(month/day/year):*

**2.** Name of ☐ **Father** ☐ **Stepfather** ☐ **Legal guardian** Birth date *(month/day/year):*

## Tell us about **health insurance, including Medicaid or Healthy Kids.**

Does anyone who is applying for medical coverage have health insurance now? ☐ **Yes** ☐ **No**
Has anyone had health insurance in the last 6 months? ☐ **Yes** ☐ **No** *If* **yes** *to either question, answer below.*

Name of **first person** with insurance now or in the last 6 months: Insurance company:

Policy/group number: Name of policy holder: Date coverage ends:

Name of **next person** with insurance: Insurance company:

Policy/group number: Name of policy holder: Date coverage ends:

Name of **next person** with insurance: Insurance company:

Policy/group number: Name of policy holder: Date coverage ends:

Name of **next person** with insurance: Insurance company:

Policy/group number: Name of policy holder: Date coverage ends:

## For **pregnant women only**

Are any of the women on this application pregnant? ☐ **Yes** ☐ **No**

First name: Middle initial: Last name:

If **yes,** does this woman want medical coverage? ☐ **Yes** ☐ **No**

Social Security Number *(only if applying for medical coverage):*

Is this woman a U.S. citizen? *(only if applying for medical coverage):*
☐ **Yes** ☐ **No**
*If* **no,** *what is her immigration status?*
.....

What is this woman's race or ethnic origin? *(you do not have to answer this question):*
☐ **American Indian/Alaskan Native** ☐ **Native Hawaiian/other Pacific Islander**
☐ **Asian** ☐ **Black/African American**
☐ **Hispanic or Latino** ☐ **Not Hispanic or Latino**
☐ **White** ☐ **Other** *(please tell us)* .....

Is this woman under age 21 and living with her parent(s)? ☐ **Yes** ☐ **No**
*If* **yes,** *list her parents and their income on page 4.*

Is this woman married? *(only if applying for medical coverage):* ☐ **Yes** ☐ **No**
If **yes,** what is her husband's name? .....
*If her husband is living in the household, list his income on page 4 under "Parent 2."*

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## Tell us about **all income for each parent or stepparent living in the home.**

**Parent 1**

Name of **first parent or stepparent:**

Is this person **self-employed?** ☐ Yes ☐ No

If **yes,** Name of Business .....

Does this person get income from **a job?** ☐ Yes ☐ No

If **no,** when was the last day this person worked? ..... Name of employer .....

If **yes,** answer below.

| **Job 1:** Name of employer: | Phone number of employer: | How much income for each pay period, **before** taxes and other deductions? |
|---|---|---|
| How often paid? ☐ **Every week** ☐ **2 times a month** ☐ **Every 2 weeks** ☐ **1 time a month** | | |
| **Job 2:** Name of employer: | Phone number of employer: | How much income for each pay period, **before** taxes and other deductions? |
| How often paid? ☐ **Every week** ☐ **2 times a month** ☐ **Every 2 weeks** ☐ **1 time a month** | | |

**Parent 2**

Name of **second parent or stepparent:**

Is this person **self-employed?** ☐ Yes ☐ No

If **yes,** Name of Business .....

Does this person get income from **a job?** ☐ Yes ☐ No

If **no,** when was the last day this person worked? ..... Name of employer .....

If **yes,** answer below.

| **Job 1:** Name of employer: | Phone number of employer: | How much income for each pay period, **before** taxes and other deductions? |
|---|---|---|
| How often paid? ☐ **Every week** ☐ **2 times a month** ☐ **Every 2 weeks** ☐ **1 time a month** | | |
| **Job 2:** Name of employer: | Phone number of employer: | How much income for each pay period, **before** taxes and other deductions? |
| How often paid? ☐ **Every week** ☐ **2 times a month** ☐ **Every 2 weeks** ☐ **1 time a month** | | |

## Tell us about **all other income.**

**Child support?** ☐ Yes ☐ No

If **yes,** name **first child** ..... How much? .....

How often? ☐ **Every week** ☐ **Every 2 weeks** ☐ **2 times a month** ☐ **1 time a month**

Name **second child** ..... How much? .....

How often? ☐ **Every week** ☐ **Every 2 weeks** ☐ **2 times a month** ☐ **1 time a month**

Name **third child** ..... How much? .....

How often? ☐ **Every week** ☐ **Every 2 weeks** ☐ **2 times a month** ☐ **1 time a month**

Name **fourth child** ..... How much? .....

How often? ☐ **Every week** ☐ **Every 2 weeks** ☐ **2 times a month** ☐ **1 time a month**

**Alimony?** ☐ Yes ☐ No If **yes,** who gets it? ..... How much? .....

How often? ☐ **Every week** ☐ **Every 2 weeks** ☐ **2 times a month** ☐ **1 time a month**



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## Tell us about **all other income.**

**Unemployment benefits?** ☐ Yes ☐ No If **yes,** who gets it? ..... How much? .....
How often? ☐ Every week ☐ Every 2 weeks ☐ 2 times a month ☐ 1 time a month

**Social Security?** ☐ Yes ☐ No

If **yes,** name **first person** who gets it ..... How much? .....

Name **second person** ..... How much? .....

Name **third person** ..... How much? .....

Name **fourth person** ..... How much? .....

**Other income?** ☐ Yes ☐ No If **yes,** what kind is it? .....

Who gets it? ..... How much? .....
How often? ☐ Every week ☐ Every 2 weeks ☐ 2 times a month ☐ 1 time a month

## Tell us about **all child or adult care expenses.**

Do you pay someone to take care of a child or adult in your household who needs care so you can work?
☐ Yes ☐ No *If* **yes,** *tell us about them:*

| | | | |
|---|---|---|---|
| **First person:** Name of the child or adult: | How old? | Full-time care? ☐ Yes ☐ No<br>Part-time care? ☐ Yes ☐ No | How much do you pay for this person weekly? |
| **Next person:** Name of the child or adult: | How old? | Full-time care? ☐ Yes ☐ No<br>Part-time care? ☐ Yes ☐ No | How much do you pay for this person weekly? |
| **Next person:** Name of the child or adult: | How old? | Full-time care? ☐ Yes ☐ No<br>Part-time care? ☐ Yes ☐ No | How much do you pay for this person weekly? |

## Tell us about **all court-ordered expenses that you pay.**

Does anyone in your household have court-ordered expenses? ☐ Yes ☐ No *If* **yes,** *tell us about them:*

Child support? ☐ Yes ☐ No
If **yes,** who pays it? ..... How much every month? .....

Alimony? ☐ Yes ☐ No
If **yes,** who pays it? ..... How much every month? .....

Wage garnishment? ☐ Yes ☐ No
If **yes,** who pays it? ..... How much every month? .....

Other? ☐ Yes ☐ No If **yes,** what is it? .....
If **yes,** who pays it? ..... How much every month? .....

## Tell us if you want **help with unpaid medical bills.**

Pregnant women and some children may qualify for help with some unpaid medical or dental bills. If you received any services in the last **90 days before this application date,** you may apply for this coverage.

Do you want to apply for this now? ☐ Yes ☐ No If **yes,** check a box to show us when you had unpaid bills.
☐ 1-30 days ☐ 31-60 days ☐ 61-90 days ***You will need proof of income for the dates you checked.***

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## Read the statements below and sign at the bottom.

**When I sign my name it means that:**

- I know that I must tell the Department of Health and Human Services (the Department) about **all** changes in my household within 10 days of the change. For example, I must tell my new address if I move, any changes in income, and any changes in the number of people living in the house.
- All of the information I gave on this application is true as far as I know.
- I know that I must give proof for the information in this application.
- I know that the Department may call other people or organizations to check the proofs I send or to get other proofs. The Department does not have to ask my permission to do this.
- I know that if I give false information or I don't give all the information that the Department asks for now or in the future, I may lose medical coverage and the Department may take legal action against me.
- I know that if I or my children are in Healthy Kids or Medical Coverage for Pregnant Women, the Department or the insurance company has the right to get all medical payments and medical support payments. I may also have to give money back for medical payments and medical support payments paid by someone else.
- I give my medical providers or my children's medical providers permission to release any medical or dental records to the Department, if necessary.
- I know that if my children are applying for Healthy Kids Gold or I am applying for Medical Coverage for Pregnant Women, we must give our Social Security numbers.
- When I say that someone applying is a U.S. citizen, it is true. I know that I may have to prove citizenship and identity of that person.
- I know that I need to qualify for Healthy Kids or Medical Coverage for Pregnant Women each year. I must complete and return a renewal application every year.
- I know that when I apply again I will have to send more proof, such as proof of income. I know that if I do not send proof, my coverage (or my children's coverage) will end.

Signature of applicant/representative_____ Date _____

## Tell us **how you heard about Healthy Kids.**

I heard about Healthy Kids Medical Insurance or Medical Coverage for Pregnant Women through:

☐ **Doctor's office** ☐ **School** ☐ **Radio, TV or newspaper** ☐ **Friend/family** ☐ **Hospital**

☐ **Other** *(please tell us)* .....



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## Social Security Numbers

The law says that we must ask for the Social Security Numbers (SSNs) of pregnant women and some children who want medical coverage. If you ask, we can tell you whose SSNs we must have.

- If someone who is applying for coverage refuses to give their SSN, it will not change anything for the other people applying on this application.
- If you can't or don't want to give us the SSN for someone on the application who is NOT applying for coverage, it will not change anything for the people who are applying on this application.

(The law is: Section 1137 of the Social Security Act)

## Citizenship and identity

The law says that we must ask about the U.S. citizenship and identity or immigration status of every child or pregnant woman who wants medical coverage. Pregnant women and some children must also give proof of their citizenship and identity or immigration status. Adults who do not want medical coverage do not have to tell us their status.

**Applying for Healthy Kids or Medical Coverage for Pregnant Women will not affect your immigration status.**

## Income

Children's income must be reported. Adults will have to give information about their income if they are:

- The parent and/or stepparent living with a child who wants medical coverage.
- Married to and living with a pregnant woman who wants medical coverage.

## Your rights

The law says we may not treat you differently (discriminate against you) because of race, age, color, creed, sex, national origin, marital status, disability or political belief. If you think we have discriminated against you, call the Ombudsman, New Hampshire Department of Health and Human Services, at (603) 271-6941 or 1-800-852-3345 Ext. 6941. TDD: 1-800-735-2964. Or write a letter to the Ombudsman at 129 Pleasant Street, Concord, NH 03301. We cannot treat you differently because you call or write.

If you think the Department of Health and Human Services made a mistake, you may ask for an administrative appeal. To ask, call a DHHS District Office or the Office of Administrative Appeals at (603) 271-4292 or 1-800-852-3345 ext. 4292 (TDD: 1-800-735-2964). You can also ask by writing a letter. Call to ask for the address.

## For application assistors only

Is there presumptive eligibility for anyone on this application?

☐ Yes ☐ No *If* **yes,** *tell us the name of the person(s):* _____

Presumptive eligibility date _____

**Complete if assisting with the application process**

I certify that I have completely explained the information on this page to the applicant. If I determined any individual presumptively eligible, I certify that:

- I have been trained by the DHHS to make this determination.
- The individual is eligible based on the information provided to me.
- I have recorded the eligibility begin date(s) above.

The Provider Number below certifies that my agency has been authorized to assist with the application process.

Signature of Application Assistor _____ Provider Number _____

Agency _____ Date _____

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Read this **list** and **send copies of proofs with your application.** If you do not send all proofs, we cannot act on your application.

## Proof of family income

**Send proof of income for:**
- each child who is applying
- parents who live with those children
- each pregnant woman who is applying
- the pregnant woman's husband if he is living with her
- parents of pregnant women under 21 if living with her

**If the person gets a salary or is paid by the hour:**
- send copies of pay stubs for the last 4 weeks, **or**
- send a letter from the employer, on letterhead, giving the hours worked and the person's gross wages for the last 4 weeks

**If the person is self-employed:**
- send the most recent income tax return with all pages, **or**
- send the most recent Profit and Loss statement, signed and dated if in business less than one year

**Other income:**
- send most recent income tax return, receipts or other proof that shows income from rent, royalties, boarders or any other kind of income
- send a copy of a letter, bank statement, or check stub that gives the amount of any benefits, such as Social Security, Unemployment, Alimony, Veterans Administration, Workers' Compensation

## Proof of New Hampshire residence

Send a copy of **ONE** of the following that shows your street address (not P.O. Box), for example:
- a lease, rental agreement, or rent receipt
- an electric, cable, heating fuel or telephone bill
- a property tax bill
- current motor vehicle registration

**If you do not have a permanent address, you may still get coverage. Please call 1-877-464-2447 for help.**

## Proof of expenses

**Child or spousal support that the court ordered:**
- send a copy of the signed court order, **or**
- send a letter from the court or from your lawyer saying that you have a support order and how much the support is

## Proof of pregnancy

Send a letter or medical form signed by a doctor or other licensed medical practitioner saying you are pregnant, and giving the due date and the number of babies due.

## Proof of health insurance

If any child or pregnant woman has insurance now, or has been insured in the past six months, please send:
- a letter saying when the coverage stopped, **or**
- an official paper from the insurance company showing the policy number, the name of the policy holder, who is covered, and for what time they are covered, **or**
- a copy of the current insurance card

## Proof of citizenship and identity or immigration status

Send a copy of **ONE** of the following for each person applying to prove citizenship and identity at the same time
- a U.S. passport
- a certificate of U.S. Naturalization
- a certificate of U.S. citizenship

If you **don't** have one of the things on the list above, please include one item from list A **and** one from list B:

**List A**
- a U.S. birth certificate
- a U.S. citizen ID card
- a final adoption decree
- an official military record
- hospital record on hospital letterhead established at the time of person's birth that indicates a U.S. place of birth

**List B**
- a driver's license
- a military or school ID card with photo
- a school, daycare or nursery record showing date, place of birth, parent(s) name and school name/address
- ID card issued by state (non-driver's identification)

**We do not ask** the U.S. Citizenship and Immigration Services about the citizenship of people on this application unless they are applying for benefits.

**IMPORTANT: Please do not send original documents. Send copies only!**

★ **Mail your application** and all proofs to NH Healthy Kids Corporation, Division of Family Assistance, 1 Pillsbury St., Suite 300, Concord NH 03301-3556. Use the envelope that came with this application.



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